LEGACY MOUNT HOOD MEDICAL CENTER

COMMUNITY NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGIES PLAN
2011/2012

CONTENTS

| l. | Introduction | Page 1 |
|-------|---|-----------|
| II. | Community Profile A. Service Area B. Population C. Racial and Ethnic Diversity | 1 |
| III. | Health Status/Health Outcomes A. Mortality B. Morbidity | 3 |
| IV. | Health Factors A. Social and Economic Factors B. Health Behaviors C. Clinical Health Care D. Physical Environment | 4 |
| V. | Stakeholder Assessment | 10 |
| VI. | Conclusion | 11 |
| VII. | Action Plan | 12 |
| VIII. | Exhibits 1. Demographics 2. Demographics by Race and Ethnicity 3. Mortality and Morbidity Rates 4. Mortality and Morbidity Rates by Race and Ethnicity 5. Social Economic and Environment Determinant Factors 6. Social Economic Determinant Factors by Race and Ethnicity 7. Clinical Care and Behavior Health Factors 8. Clinical Care and Behavior Health Factors by Race and Ethnicity 9. Sources | 13 |
| IX. | Appendices | 27 |
| | A. Community Health Characteristics Most Important B. Community Health Greatest Needs/Issues C. Health Care and Public Health Greatest Needs/Issues D. Hospitals' Roles E. Health Needs Ranked by Priority F. Interviewees | |

INTRODUCTION

Legacy Mount Hood Medical Center traces its history back to the establishment of a medical clinic in Gresham in the early 1900s. In 1959 it became a hospital and in 1984 it was built on the current site. Legacy Mount Hood is a member of Legacy Health, a five hospital system established in 1989 by the merger of two nonprofit systems in metropolitan Portland Oregon. Legacy's mission is "Good health for our people, our patients, our communities, our world."

Consistent with this mission, in fiscal year 2011 Legacy Mount Hood provided \$8.9 million in charity care; total unreimbursed costs of care for people in need amounted to \$12.6 million. Charity care alone amounted to 9.2 percent of operating expenses and total unreimbursed costs were 13.0 percent of operating expenses. Legacy Mount Hood's care for the uninsured and low income as a percent of revenue was the highest of the fourteen hospitals in the metro area in 2010—the most recent state data published.

A model developed by the University of Wisconsin provides a rubric for examining the many factors contributing to a community's health. The four groups of factors are Social and Economic, Health Behaviors, Clinical Care, and Physical Environment. Aligned with these factors, the Legacy Mount Hood Community Needs Assessment 2011 addresses issues key to the health of a community beyond the health care delivery system. The purpose of this Assessment is to determine the priority factors influencing the health of the community and to identify how Legacy's resources and expertise can be matched with external resources to optimally address those issues. The community is defined as the primary service area (five mile radius).

Quantitative secondary data for this analysis is focused on demographic characteristics, health factors, and health outcomes derived from a review of national and local research. Data is the most recently available—years range from 2007 to 2010. Data at the primary service area level is used when available, followed by county (Multnomah) and Oregon state in order of preference and availability. Race and ethnicity data is most commonly available only at the county and/or state level. Because East County accounts for a portion of the entire county population, the use of county-level data must be viewed with caution. Qualitative information is especially beneficial.

Qualitative research consists of interviews conducted by leadership with 56 elected officials (state, county and city) and public sector (public health, human services), faith, business and community members. Interviews occurred between August 2010 and January 2011. An exhibit lists interviewees, by title and organization and identifies those with expertise in public health and/or with the medically underserved, low-income and/or communities of color populations.

Exhibits and Appendices provide data detail, sources and needs.

COMMUNITY PROFILE

Service Area

Legacy Mount Hood is located in Gresham, a suburban area about 35 miles east of downtown Portland. The total service area extends from the Columbia River in the north to Estacada in the south and from 122nd Avenue in the west to Mt. Hood in the east. The primary service area (the five mile radius) includes the cities/towns of Gresham, Troutdale, Fairview and Wood Village.

While Gresham is the fourth largest city in Oregon, the other communities are much smaller in population. The communities are contiguous to each other. People living in this area perceive themselves as distinct from Portland, Oregon, although the majority works in Portland. The towns have strong local governments and identities.

The primary service area is situated in the eastern third of the same county as the larger urban core--Portland (referred to as East Multnomah County). This presents challenges as the urban center/county seat consumes the majority of dollars and services. East Multnomah County often feels forgotten. The situation is especially pressing as demographics are shifting such that East Multnomah County requires additional services and dollars, but struggles to be heard relative to Portland. The area is working diligently to have a stronger employment base—critical for schools, public sector services and autonomy within the county.

Population

In November 2010, the Portland State University (PSU) Population Research Center reported the Oregon metro area tri-county population at 1,644,535 residents; with Clark County, the four county area was 2,080,926.

The primary service area included 116,486 people in 2010; projected 1.5 percent annual growth between 2010 and 2015 is among the highest of the Legacy Health hospital service areas. East Multnomah County is expected to grow at a higher rate than West Multnomah County—the city of Portland. Zip codes include: 97030, 97060, 97230, 97233, 97236, 97019 and 97080.

The population in East County is younger than overall Multnomah County and Oregon. Median age was 37.8 years in Oregon in 2009. Multnomah County was 36.9 years. In comparison, Gresham and Troutdale median ages were 32 years. 27 percent of Gresham and 22 percent of Troutdale is under 18 years of age as compared to 30 percent of Multnomah County.

Racial and ethnic diversity

By ethnicity, in 2010 the Legacy Mount Hood primary service area was 78.9 percent non-Hispanic white, 11.9 percent Hispanic, 3.2 percent Asian, and 3.0 percent bi-racial, 1.9 percent African American and .7 percent Native American. It is commonly recognized that communities of color may be undercounted in census numbers. As home and rental costs in the City of Portland have increased significantly in the past decade, communities of color have sought housing in the surrounding communities. The range of languages spoken at home is significant within segmented areas of East Multnomah County. More than 45 languages are spoken in the East County public schools. The Slavic community, in addition to the Hispanic community, has settled in the area.

Hispanics are moving into the area at a higher rate than any other group (more than doubling in numbers in the past 15 years) and have a higher birth rate than other communities of color. The Hispanic population accounts for about one-fifth of the births in Oregon and Washington, while they make up just one-tenth of the population. Between 1995 and 2004 babies born to Hispanic mothers increased 67 percent. It is projected that communities of color will make up the majority of the Oregon population by 2040, and that 25 percent of the population will be Hispanic. A number of the elementary schools in East County are 50 percent Hispanic.

The immigrant and refugee population is increasing significantly. Recent immigrants and refugees are more likely to be culturally and linguistically isolated. Speaking a language other than English at home has increased significantly, particularly in East County and specific neighborhoods such as

Rockwood—located on the edge of west Gresham. Spanish is the most common language spoken with Slavic languages following.

The African American/Black population continues to be most concentrated in the historical neighborhoods of North/Northeast Portland, but increased housing prices have resulted in the community moving increasingly to East Multnomah County.

While still a small population relative to the entire metro area, specific geographic areas are experiencing significant growth in the Slavic population, particularly in the southern East Multnomah County. Slavs are counted in the non-Hispanic white population, but they have distinct cultural identity. Their socioeconomic indicators are generally lower than the other non-Hispanic white population.

While the area's population is growing slowly, its composition is changing dramatically. Legacy Mount Hood's service area is experiencing significant increases in demographics that have lower income levels, less education, lower health status, and lower health literacy.

HEALTH STATUS/HEALTH OUTCOMES

The health status of the area can be analyzed using both vital statistics and accepted indicators of health status.

Mortality

The Crude Death Rate and Age Adjusted Death Rate in Oregon were greater than the national average in 2007. County level age adjusted death rates showed Multnomah County to be much higher than the state rate. Premature death rates were aligned in a similar pattern.

The most common causes of mortality in Oregon is consistent with the national most common disease deaths—heart and cancer. In 2006 Multnomah County experienced the highest rate among the four metro counties both in cancer and heart deaths.

Infant mortality is an accepted indicator of a community's health status. In 2006 Multnomah County was higher than the state rate and the highest among the four metro counties—6.3/1000 compared to the state's 5.7.

Morbidity

A community's health morbidity statistics commonly include those diseases most related to high mortality (heart, cancer and low birth weight), chronic conditions such as cardiovascular disease, diabetes and asthma and self-reported health and mental health status (the latter have been statistically validated as predictors of community health status). Individuals with multiple chronic diseases often also experience other risk factors such as obesity and smoking, and use health care services to a greater degree.

The economic cost of racial and ethnic disparities is significant. The Urban Institute reports the estimated national cost of racial and ethnic disparities for African Americans and Hispanics in 2009 (calculated based on change in expenditure if the cohort's age specific prevalence rates were the same as non-Hispanic whites) was \$23.9 billion.

Low birth weight

Low birth weight is correlated to adult morbidity, specifically hypertension, diabetes and heart disease. In 2007 low birth weight in Oregon was 6.1 percent with Multnomah County exactly the same. Hispanic women's low birth weights and infant mortality rates were equal to non-Hispanic whites at the state level even though prenatal care percents were over 12 percentage points less. This information is consistent with national data.

Heart disease

Major risk factors for heart disease are smoking, lack of physical exercise, hypertension and overweight/obesity. In 2006, the cost of hospitalizations in Oregon for heart and stroke totaled more than \$1.2 billion. As with heart disease mortality, communities of color experienced the greatest morbidity rates (disaggregated data by county is not available). In 2009, age adjusted coronary heart disease prevalence in Oregon was 4.0 percent for African Americans, 8.0 percent for Native Americans, 4.0 percent for Asian/Pacific Islanders and 2.0 percent for Hispanics compared to 4.0 percent for non-Hispanic whites. The prevalence of hypertension among Oregonians has been stable the last few years while the prevalence of high cholesterol increased.

Cancer

Oregon, US and Multnomah County cancer incidence per 100,000 in 2007 were within significant differences of each other—about 466. National Cancer Institute data not detailed here showed Hispanic and Asians with the lowest rates among races and ethnicities.

Diabetes

Diabetes is increasing at an alarming rate. The prevalence in Oregon is 35 percent higher than ten years ago. People with diabetes are more likely to also have heart disease and self-report their general health as fair or poor as compared to good or excellent. Diabetes prevalence was 7.3 percent in Multnomah County as compared to 6.9 percent in Oregon in 2008. The elderly are more likely to have diabetes (15 percent of Oregonians 65 years and older) as are low income persons.

Diabetes is more prevalent in communities of color. Percentages in Oregon in 2005 were: African Americans (13 percent), Native Americans (12 percent), Hispanics (10 percent) and Asians (7 percent) non-Hispanic whites (6 percent). According to studies, communities of color are also more likely to have diabetes-related complications at two to four times the rate of non-Hispanic whites. This is seen as due to poorer control of the disease and co-morbidities, i.e., high blood pressure and cholesterol, as well as poorer access to care.

HEALTH FACTORS

The previous section outlined the current health status of the area. In this section, we examine the factors that lead to that status. A community's health is the product of many different factors. A model developed by the University of Wisconsin provides a useful rubric for examining them. The four groups of factors are Social and Economic, Health Behaviors, Clinical Care, and Physical Environment. This section of this report is arranged according to these factors. The following chart shows the factors and the percentage impact they are thought to have on community health status:

| Social and Economic | 40% |
|----------------------|------|
| Health Behaviors | 30% |
| Clinical Care | 20% |
| Physical Environment | 10% |
| · | 100% |

Social and Economic Factors

Social and Economic Determinants include education, health literacy, employment, income, housing and community involvement.

Education

Education is often cited as the key to upward social and economic mobility for individuals and, in turn, a community's health status. Research has concluded that if Americans without a college degree experienced the lower death rates and better health of college graduates, the improvements in health status and life expectancy would be more than \$1 trillion annually.

The 2009 the high school graduation rate of individuals 25 and older in Multnomah County (89.0 percent) was equal to the state average; the college degree rate at 39.1 percent for people 25 years and older was 10 percentage points better than the state average. Again, disaggregation reflects distinct differences among ethnicities and races. The high school completion rate of non-Hispanic whites in Oregon is 91.4 percent, compared with 86.6 percent for African Americans, 85.6 percent for Asians, 84.1 percent for Native Americans, and 54.7 percent for Hispanics. College completion rates have a similar pattern: 29.2 percent for non-Hispanic whites, 20.1 percent for African Americans, 12.8 percent for Native Americans, and 10.4 percent for Hispanics. The outlier is the much higher college graduation rate for Asians, at 45.7 percent.

The combination of disparities in educational achievement among race and ethnic cohorts and the increasing diversity of the total population are resulting in the younger current generation not meeting prior generation rates of high school and college completion.

Gaps in achievement begin in early childhood. Children entering first grade without school readiness skills continue to be behind throughout school. Children of racial and ethnic diversity are more likely to enter school lacking these skills. With the increasing diversity in the service area, the overall graduation rate will continue to decline.

Health literacy

Health literacy is linked to functional literacy – reading, writing, arithmetic – but also includes a social dimension. It is the ability to obtain, process and understand health information in order to make appropriate health decisions and practice positive health behaviors. The National Patient Safety Foundation has said that no other single factor has as great an influence on health status, and studies have determined that health care utilization and expenditures are far greater in the presence of low health literacy.

Nearly half of the US adult population has low health literacy. Low health literacy is a quality and cost issue for patients and society. Patients with low health literacy are less likely to comply with treatment, are less likely to seek preventive care, and enter the health care system sicker. Patients with low health literacy are twice as likely to be hospitalized. Annual health care costs for people with low health literacy are four times higher. The economic burden of low health literacy has been variously estimated to be \$106-238 billion annually. Higher illness rates mean lower productivity at work, and poor parental health often results in low student school attendance – with a direct correlation to lower educational achievement.

Evidence points to low health literacy as a significant cause of low patient compliance, which in turn is correlated with provider dissatisfaction. Patients out of compliance have a lower quality of care and lower quality of life.

We do not have local data on low health literacy, but nationally research has shown that specific populations are particularly at risk:

- Hispanic, African American, and Native American populations
- Recent immigrants
- People age 65 and older.

The growth of communities of color in the area will present significant challenges to health care providers by increasing the prevalence of low health literacy. If the number of insured people is increased by health care reform, the bulk of the newly insured will be from those populations most at risk for low health literacy: minorities and the poor. Unlike many modifiable health behaviors, the onus for dealing with health literacy falls primarily on health care providers.

Employment/Income

Educated workers attract higher wage businesses to the community. Higher wage jobs mean higher worker benefits and disposable incomes. Employment is correlated to levels of income, family and support systems and community safety. When these are jeopardized, health status is challenged.

Oregon has particularly suffered in the current recession, ranking second in national unemployment at times. In 2009 Oregon had an unemployment rate of 11.8 percent as compared to the US's 9.9 percent. Multnomah County was just barely under the state average at 11.5 percent. Oregon's median household income in 2009 was \$48,475. Multnomah County showed a higher median household income than the state.

Race and ethnic cohorts varied greatly. In Multnomah County, incomes were the highest for non-Hispanic whites and lowest for Native Americans—a \$28,000 difference. African Americans were just \$5,000 higher than Native Americans. In contrast, Asians were just \$3,000 less than non-Hispanic whites. Poverty is highly correlated to poor health. Persons with lower incomes are more likely to have chronic diseases, higher acuity illness, disability and premature death. Low income individuals are much more likely to self-report themselves (and their children) as being in poor or fair health compared to people with increased incomes.

Oregon all age poverty revealed race and ethnic Hispanic and Native American at double and African American at nearly triple that of non-Hispanic whites. Households headed by females are even more at risk for poverty. In Oregon in 2008, more than 50 percent of Hispanic families headed by females were at poverty level compared to one-third of non-Hispanic white families headed by females.

Poverty is increasing with the distinct shift in employment industries—moving from manufacturing and resources (lower-skilled employees with higher paying jobs) to service sector (lower wage jobs). Jobs paying less than \$30,000 annually have accounted for 63 percent of all net job growth since 2000. Nearly sixty percent of families living below the federal poverty line have a household member who works and 14 percent have a full-time year-round worker.

Housing

Home ownership is considered a significant contributor to long-term stability and, in turn, positively correlated to education achievement and better health status and income. Among the four metro counties, Multnomah shows the lowest home ownership rate at 54.9 percent in 2009--nearly ten percentage points lower than the state. Race and ethnic differences are apparent. In 2009 in Oregon, 70.9 percent of non-Hispanic whites owned homes as compared to 48.0 percent Hispanics, 44.5 percent African Americans, 54.6 percent Native Americans and 59.0 percent Asians/Pacific Islanders.

The national standard is that renters should not pay more than one-third of their income in rent. Oregon is ranked third in most unaffordable rental markets in the nation. In 2009 42.4 percent of renters in Multnomah County fell into this category. Multnomah County also ranked highest among the four metro counties in all poverty, children in poverty and unemployment.

Health behaviors

Individual behaviors account for the second greatest weighting among Health Factors. Risk factors such as obesity, tobacco use and substance abuse are each significant contributors to mortality and morbidity.

Obesity

Obesity is now considered among the top public health issues in the country. Reduced physical activity, convenience, and fast foods have doubled the rates in adults in the last two decades. In Oregon in 2009, nearly 60 percent of adults were overweight or obese and about 25 percent were obese. Multnomah County showed 20.5 percent of adults to be obese. Obesity has consequences beyond the condition itself. It is a leading risk factor for diabetes, hypertension, heart disease, stroke and other diseases.

The increasing prevalence of childhood overweight and obesity is of concern. It results in increased risk of chronic disease, asthma, respiratory problems, orthopedic conditions and being overweight or obese in adulthood. Centers for Disease Control research reports that the prevalence of childhood obesity tripled nationally between 1976 and 2008—from 5.5 percent to 16.9 percent. Adding in the percentage that was overweight, nearly 50 percent of children were overweight or obese nationally in 2008. While all age cohorts increased rates, teens increased the most. One measure of the effect of obesity on health and health care costs is the projection that one third of all children and 50 percent of children of color born in 2000 will acquire Type 2 diabetes.

Tobacco use

Smoking is considered one of the two most prominent individually based risk factors for disease and the most preventable cause of death and disease. Smoking is correlated to cardiovascular disease and cancers including lung, cervix and bladder. Adults with three or more chronic diseases are three times more likely to have smoked or be current smokers.

Oregon adult smoking prevalence decreased 19 percent and 11th grade smoking 20 percent over the past ten years due to state prevention efforts, higher cigarette taxes and bans on smoking in public places. The state's adult smoking rate in 2009 was 19 percent and Multnomah County was 20 percent. Still, these rates are unacceptably high.

Teen births

Teen birth is one of the most powerful predictors of poverty. Teen birth rates (ages 15-19 years) are decreasing--in Oregon by over a third between 1991 and 2006. In 2006, Multnomah County was the highest among the four metro counties and 15 births greater than the national target of 24/1000. Race and ethnicity data showed significant differences in 2007 in Oregon. Ranked in order from lowest to highest—Asians: 15, non-Hispanic whites: 27, Blacks: 44, Native Americans 54 and Hispanics 93. Thus, there was a 75 birth per 1000 teen difference between Asians (lowest) and Hispanics (highest). State level trending data is not available, but the Guttmacher Institute reported nationally that teen pregnancies fell in all race and ethnicity cohorts between 1990 and 2005: non-Hispanic whites—50 percent decrease, Blacks 45 percent and Hispanics 26 percent.

Clinical health care

Health care services

The Legacy Mount Hood primary service area is the sole hospital in the primary service area. Three other health systems have a strong clinic presence.

With the increase in diversity and decreasing family incomes in the area, safety net services have expanded and emerged. Multnomah County Health Department operates FQHCs in inner Gresham and Rockwood, a neighborhood on the western edge of Gresham (the site of one of the highest Community Needs Index scores in the entire metro area). Two safety net clinics serve the area—volunteer staffed Wallace Medical Concern (financial donation, board representation and inkind lab services donated by Legacy) is also in Rockwood and a physician staffed nonprofit is in Gresham. Wallace recently moved into a permanent expanded space, is seeking FQHC look-alike status and projects serving 5900 patients annually within the second year of the move.

One-fourth of the census tracts in Rockwood have "Medically Underserved Population" designation with an uninsured population of 30%. Legacy Medical Group Clinic in Sandy—13 miles from the hospital--is a designated Rural Health Center. A local nonprofit, Project Access NOW, links uninsured low income individuals to providers and health system services providing services at no charge. All of the health systems in the metro area are very involved with this program and Legacy Health, in addition to providing clinical services, provides and cash donation and office space to the administrative offices of Project Access NOW inkind.

Services to those in need

Legacy Mount Hood's charity care policy includes patients with incomes up to 400 percent of the Federal Poverty Level. Eighty percent of uninsured patients do not pay anything and 15 percent pay a small portion of their bill. In FY 11, Legacy Mount Hood provided \$8.9 million in charity care and \$12.6 million in total unpaid costs of care for those in need. Legacy Mount Hood was the highest charity care provider as percent of charges among all metro area hospitals in 2010—at 9 percent.

Access to care

Lack of access is correlated with increased rates and severity of chronic diseases, hospitalizations and mortality. Access is influenced by a number of factors: health insurance, proximity to services, transportation, income, culture, language, and provider acceptance of uninsured, Medicaid and Medicare patients.

The poor and communities of color have a disproportionate impact from lack of access to care. The Agency for Health care Research and Quality reports that Hispanics receive worse care across 60 percent of core quality measures. The Robert Wood Johnson Foundation reports that low income people on average receive worse care across 12 of 17 quality measures, including access to care, cancer screening and preventive health services.

Health insurance

Health insurance coverage is significantly correlated to health status. The uninsured are 2.8 times more likely than the insured to be hospitalized for diabetes, 2.4 times more likely for hypertension and 1.6 times for pneumonia. One study reported that case management of Oregon Health Plan patients showed a 43 percent reduction in emergency department visits.

Oregon has had a high uninsured rate as compared to the nation—in 2010 at 18.0 percent (600,000 people under 65 years).

In 2009 Multnomah County experienced a 16.8 percent uninsured rate. Forty percent of the 100,000 residents in Rockwood live at or below 200 percent of FPL and 30 percent have no health care coverage. Adults 18 to 64 years are more likely to be uninsured than children or seniors. Nationally, 50 percent of the uninsured are people of color. Uninsured rates vary significantly by race and ethnicity in Oregon. In 2008, Native Americans and Hispanics experienced nearly triple the uninsured rates of non-Hispanic whites—29.3 percent and 28.2 percent as compared to 11.3 percent.

Provider and service availability

Oregon average of primary care provider availability is 40 providers less than the target of 175 per 100,000 people. The rates differ enormously among counties, consistent with hospital locations and population density. In 2007, Multnomah County's 211/100,000 was the highest of all state counties; the majority of the providers, particularly specialists, were located in Portland surrounding the tertiary hospitals. Availability is a particular issue in low income areas, where physicians do not tend to locate.

Preventive screenings are an additional indicator of health care access. Sigmoidoscopy/ colonoscopy rates 50 years plus, cholesterol screenings and diabetic screenings 65 years plus were 67.7 percent, 73.9 percent and 84 percent in Oregon as compared to national target rates (90th percentile) of 61.8 percent, 77.0 percent and 88 percent respectively. Thus, Oregon is over the target for sigmoidoscopy/ colonoscopy and under the others.

Receiving prenatal care in the first trimester is a health care access indicator and correlated to low birth weight and infant mortality. In 2006, Oregon's rate of women obtaining prenatal care in the first trimester was 79.2 percent and Multnomah County was 78.4 percent. Disparities in accessing prenatal care among race and ethnicity cohorts at the state level were described in the Morbidity sections, including how different races and ethnicities display greatly varying low birth weight and infant mortality numbers.

Childhood immunization rates are also an indicator of health care access. In 2009, 72 percent of children 19-35 months in the US had their immunizations as compared to 67 percent in Oregon. The national goal is 80 percent.

Physical environment

The physical environment plays a role in community health. Indicators that are tracked include quality (air, noise and water) and the built environment (access to healthy food, transportation, trails and sidewalks). Research over the last two decades clearly identifies the relationship between neighborhoods with higher income families and increased access to grocery stores and availability of physical access opportunities, e.g., sidewalks, trails. Some studies have even suggested that health status can be correlated with zip code, which the CNI method validates.

Access to healthy food makes healthy choices easier. The Urban and Environmental Policy Institute in 2002 reported that middle and upper income neighborhoods had twice as many supermarkets as low-income neighborhoods. The national target is that 70 percent of a community's census tract boundaries will be within one half mile of a healthy food retail store. Within Oregon in 2006, only 47 percent of the state's census tracts met this target. Multnomah County was 45 percent. Access to healthy food is a serious problem in many parts of our service area. As can be experienced driving through some low income neighborhoods in East County, the lack of large grocery stores is evident.

The number of liquor stores per 10,000 people is a reverse health status indicator. Multnomah County at .7 was higher than the state and highest among all metro area counties. Multnomah County has the greatest population density, highest poverty levels, and lowest health status.

STAKEHOLDER ASSESSMENT

Quantitative research provides a detailed look at data and trends in specific population cohorts. One-on-one interviews with key stakeholders provide context. Between August 2010 and January 2011 Legacy Mount Hood and Legacy Health management interviewed 56 elected officials and public sector (public health, human services), and faith, business and community leaders, including representatives of culturally, racially and ethnically diverse communities. Interviewees were intentionally designated based on their direct involvement with organizations and/or issues in the service areas, i.e., they have played visible roles in meeting community needs.

A standard set of questions elicited responses encompassing community health, primary issues facing the community, health and public health issues, roles of health systems in addressing needs and whether issues for people of cultural, racial and ethnic diversity differed from other populations.

Stakeholders provided a rich interpretation of community health including types of care (e.g., physical, mental, dental), social determinants (education, income/jobs, health care, community engagement, environment and housing) to individual assets (e.g., stability, emotional spiritual, holistic, opportunity), individual assets (e.g., stability, emotional, spiritual) and community assets (e.g., interconnectedness, access, quality, interdependence). A thread of 'inclusion' ran through most of the interviews, a belief that all individuals must have access to a community's assets and that disparities and inequities must be challenged and addressed in order for a community to truly 'healthy.' As with our earlier examination of data concerning the factors that influence a community's health, the actual provision of health care services was seen by most respondents as less important than economic and social factors.

Following is a summary of what we learned from the stakeholders. Percentages are based on the number of mentions due to respondents providing more than one designation.

Community health characteristics

Asked about the definition of "community health" and what a healthy community looks like, stakeholders designated the three most important characteristics in a community's health from a list. Education, Income/Jobs and Health Care and Access were cited the most in this order. Adding those who cited Public Health to Health Care, the percent rose to place it first. These three characteristics were each more than twice the others. Housing, Social/Human Services and Community Involvement followed in rankings.

Community needs/issues

Assessment of community needs and issues reflects the gap between the previous question's ideal state and the current reality. The three most important characteristics of a healthy community were cited as the three greatest issues, but in a different order. Income/Jobs switched places with Education. Health Care and Access remained in third place. Disparities and equity issues are seen as barriers to the higher-level items like Income/Jobs and Access to Health Care as Diversity/Disparities/Equity/Culturally Appropriate moved to fourth place. There was a consistent

theme about the lack of voice for communities of color and institutional racism resulting in disparities and inequities.

Health care/Public health issues

Specifically questioned about Health Care/Public Health needs, Access for Low Income and Uninsured (coverage, cost, primary care shortage/access and affordability) was listed nearly a third of the time, followed by Mental Health and/or Addiction/Substance Abuse. Concern about issues related to cultural competency, disparities, equity and racism were cited one out of ten times. Interviewees were vocal about health disparities for communities of color and some proposed that an equity lens be used in looking at all issues and needs. Concerns about the impact on the future generation of the significantly increasing numbers of chronic disease and obese children were shared, particularly for communities of color due to the adult mortality and morbidity disparities resulting. Chronic Disease, Obesity, Dental, Nutrition/Hunger, Prevention and Education, Built Environment and Violence: Domestic and Child then followed in order. These concerns center on the role of government, specifically health policy.

Racial and ethnically diverse community issues

We asked specifically about health disparities for communities of color, given the findings of our data review that demonstrated significant and increasing concerns in this area. The majority of stakeholder input indicated that the health care and social needs of these populations were essentially the same, but that the intensity of the needs were exacerbated; i.e., communities of color have fewer resources and experience magnified barriers across all factors. Several respondents noted that these communities do not have sufficient voice in policy discussions and civic projects.

Hospitals' roles

Stakeholder recommendations for the role of hospitals in community health centered primarily on relationships, leadership and advocacy. Recommendations were for increased partnerships with community based organizations in terms of services, dollars, and labor, prevention and education, increased collaboration with other health systems, health care access for the uninsured and advocates with legislators and elected officials... Stakeholders felt that health systems would influence issues most effectively and efficiently by working in broader and deeper partnerships with fewer organizations.

CONCLUSION

Significant segments of the population in the Legacy Mount Hood service area are less well-off across a range of measures – economics, education, health, and more. Communities of color bear a disproportionate burden. County level data shows consistent race and ethnic data disparities across indicators.

Additionally, the size of communities of color in the Legacy Mount Hood area is growing rapidly. If economic, education, and social systems do not change course to reduce historic inequities, they will only become a greater factor in the community's health. One of the promises of health care reform is coverage for those who currently do not have health insurance. The newly insured will be disproportionately from communities of diversity, and thus as a whole this newly insured population

will be significantly less educated, poorer, and have lower health status and greater health care needs.

If we are to address the health care-related needs of the Legacy Mount Hood area, and turn first to the most serious need, that need is found in communities of color, particularly in the Latino community. Our mission and our desire to have the greatest impact possible leads us to consider our community benefit activities through this lens.

The range of possible activities is tremendous, so we prioritize using the following broad criteria:

- 1. Size: The number of people affected, and the geography impacted.
- 2. Seriousness: The impact on the area's health, on its economic strength, and on its institutions.
- 3. Change Potential: The potential for positive intervention, and the sustainability of positive impact.
- 4. Legacy and Legacy Mount Hood's strategic plans: The alignment of the issue with one of the health system's areas of strategic focus and mission and the hospital's strategic focuses.
- 5. Capacity: The extent to which Legacy Mount Hood has the resources and expertise to have a significant impact.

ACTION PLAN

Using these criteria and the lens of racial and ethnic equity, a Legacy Mount Hood Medical Center Implementation Strategies Plan details needs and implementation strategies in order of priority. All needs expressed by stakeholders related to health, health care and public health are listed, including those not addressed as a focus priority due to lack of financial and labor resources. Many needs beyond the five focus areas are addressed within hospital services and activities and these can be found in the Plan. Legacy Mount Hood's resources and strengths are on health-related services and, thus, the five focus areas are health-related needs and actions. Community stakeholders clearly stressed recommending focused attention in contrast to a broader superficial approach in addressing issues.

Based on the criteria, Legacy Mount Hood will focus on:

- communities of color
- charity care
- access to health care
- health literacy
- youth and education.

IMPLEMENTATION STRATEGIES PLAN

The Legacy Mount Hood Medical Center Implementation Strategies Plan follows Exhibits and Appendices. The Plan addresses health and public health needs identified in the research.

Exhibit 1: Demographics

| | Data Year/ Source | US | OREGON | WASH. | Clackamas | Clark | Multnomah | Washington |
|---------------------------------------|----------------------|-------------------------|-------------------------------|------------------|------------|-----------------|-----------|------------|
| Total Population | 2009/1 2010*/2 | 307,006,556 | 3,844,195* | 6,664,195 | 381,775 | 436,391 | 730,140 | 532,620 |
| Live Births | 2007,09,07 /3,4,5 | 4,324,008 | 49,373 | 89,200 | 8.2% | 6.8% | 20.8% | 15.9% |
| Gender | | | | | | | | |
| Male | 2009/1 | 49.3% | 49.6% | 49.9% | 49.5% | 49.8% | 49.6% | 50.1% |
| Female | 2009/1 | 50.7% | 50.4% | 50.1% | 50.5 % | 50.2% | 50.4% | 49.9% |
| Age | | | | | | | | |
| Median Year | 2009/1 | 36.7 | 37.8 | 37.1 | 38.9 | 35.1 | 36.9 | 35.0 |
| Under 5 years | 2009/1 | 6.9% | 6.4% | 6.6% | 5.6% | 7.0% | 6.8% | 7.5% |
| 5 to 19 years | 2009/1 | 14.0% | 19.3% | 19.9% | 20.0% | 21.9% | 18.2% | 20.9% |
| 20 to 44 years | 2009/1 | 34.5% | 34.0% | 35.1% | 32.6% | 35.7% | 37.7% | 37.7% |
| 45 to 64 years | 2009/1 | 32.0% | 27.3% | 26.7% | 29.8% | 25.2% | 26.9% | 24.9% |
| 65 years & older | 2009/1 | 12.6% | 13.0% | 11.7% | 12.0% | 10.2% | 10.4% | 9.0% |
| Lang. Other Eng. Spoken at Home | 2009/6 | 20.0% | 14.6% | 17.0% | 11.9% | 13.3% | 18.6% | 22.9% |
| Population Growth | Year | 4 Counties | OREGON | | Clackamas | Clark | Multnomah | Washington |
| | 2010/6 | 2,080,926 | 3,844,195 | | 381,775 | 436,391 | 730,140 | 532,620 |
| | 2015/6 | 2,187,871 | 3,941,265 | | 391,415 | 476,850 | 759,817 | 559,789 |
| Annual Increase | 2010-15 | 1.0% | .5% | | .5% | 1.9% | .8% | 1.0% |
| | | Primary Service Area | Emanuel/ Good Samaritan | Meridian Park | Mount Hood | Salmon Creek | | |
| | 2010/7 | 948,044 | 443,503 | 226,068 | 116,486 | 161,987 | | |
| | 2015/7 | 1,005,822 | 458,517 | 242,530 | 125,479 | 179,296 | | |
| Annual Increase | 2010-15 | 1.2% | .5% | 1.5% | 1.5% | 2.1% | | |

Exhibit 2: Demographics by Race and Ethnicity

| | | Data Year/ Source | Total | Non- Hispanic White | Hispanic | Black/African American | Native American | Asian | 2 or more races |
|--------------------------------------|---------------------------|----------------------|-----------|---------------------------|----------|---------------------------|--------------------|--------|-----------------------|
| Total Population | OR | 2008/1,2 | 3,790,060 | 79.9% | 11.0% | 1.7% | 1.7% | 3.4% | 3.5% |
| | WA | 2008/2 | 6,549,224 | 75.3% | 9.8% | 3.4% | 1.4% | 6.5% | 4.0% |
| | Total GPA | 2010/3 | 2,120,737 | 76.7% | 10.7% | 2.9% | 0.7% | 5.6% | 3.0% |
| Primary Service Area (five miles) | Emanuel/Good Samaritan | 2010/3 | 443,503 | 74.1% | 8.6% | 6.6% | 0.7% | 5.9% | 3.4% |
| | Meridian Park | 2010/3 | 226,068 | 81.9% | 8.8% | 1.0% | 0.4% | 5.0% | 2.5% |
| | Mount Hood | 2010/3 | 116,486 | 78.9% | 11.9% | 1.9% | 0.7% | 3.2% | 3.0% |
| | Salmon Creek | 2010/3 | 161,987 | 88.3% | 5.8% | 1.2% | 0.6% | 1.5% | 2.4% |
| County | Clackamas | 2009/4 | 386,143 | 84.6% | 7.6% | 1.1% | 1.0% | 3.8% | 2.4% |
| | Multnomah | 2009/4 | 726,855 | 73.6% | 10.9% | 6.0% | 1.2% | 6.1% | 3.1% |
| | Washington | 2009/4 | 537,318 | 71.2% | 15.3% | 2.1% | 1.0% | 8.7% | 2.6% |
| | Clark | 2009/4 | 432,002 | 83.3% | 7.1% | 2.2% | 1.0% | 4.0% | 2.6% |
| | Four Cty Area | 2009/4 | 2,082,318 | 77.0% | 10.6% | 3.3% | 1.1% | 5.9% | 2.7% |
| Live Births | OR | 2007/5 | 49,378 | 69.4% | 20.5% | 2.3% | 1.7% | 5.4% | N/a |
| | WA | 2007/5 | 88,978 | 63.3% | 18.9% | 4.3% | 2.0% | 9.3% | N/a |
| Gender | OR M | 2008/1,2 | 49.7% | 49.1% | 54.2% | 53.0% | 48.8% | 46.3% | 49.0% |
| | OR F | 2008/1,2 | 50.3% | 50.9% | 45.8% | 47.0% | 51.2% | 53.7% | 51.0% |
| | WA M | 2008/2 | 49.9% | N/A | N/A | N/A | N/A | N/A | N/A |
| | WA F | 2008/2 | 50.1% | N/A | N/A | N/A | N/A | N/A | N/A |
| Age | | | | | | | | | |
| Under 5 years | OR | 2008/1,2 | 6.4% | 5.2% | 13.3% | 8.3% | 6.0% | 6.2% | 13.3% |
| 5 to 17 years | OR | 2008/1,2 | 19.2% | 14.9% | 26.3% | 21.7% | 22.3% | 15.9% | 29.6% |
| 18 to 44 years | OR | 2008/1,2 | 33.6% | 34.9% | 45.4% | 39.1% | 38.9% | 46.4% | 35.7% |
| 45 to 64 years | OR | 2008/1,2 | 27.6% | 29.9% | 12.1% | 23.4% | 26.2% | 23.1% | 16.5% |
| 65 years and older | OR | 2008/1,2 | 13.2% | 15.1% | 2.9% | 7.5% | 6.7% | 8.5% | 4.9% |
| Total | OR | 2008/1,2 | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

Exhibit 3: Mortality and Morbidity Rates

| Age Adjusted: AA | Data Year/ Source | US | OREGON | WASH. | Clackamas | Clark | Multnomah | Washington |
|---|------------------------|-------|--------|-------|-----------|-------|-----------|------------|
| / tgc / tajastea. / t/ t | Course | | | | | | | |
| Mortality /100,000 | | | | | | | | |
| Total Death Rate Crude | 2007/1 | 803.6 | 838.0 | 731.6 | N/A | N/A | N/A | N//A |
| Death Rate AA | 2006/1,4 | 760.2 | 770.5 | 722.5 | 766.5 | 745.1 | 833.0 | 684.7 |
| Premature Death | 2006/5 | N/A | 653.7 | 597.9 | 541.8 | 573.2 | 699.9 | 462.4 |
| Heart Death Rate AA | 2006/1,4 | 190.9 | 160.1 | 165.8 | 161.4 | 176.7 | 175.3 | 146.2 |
| Cancer Death Rate AA | 2006/1,4 | 178.4 | 181.3 | 174.2 | 187.8 | 176.0 | 188.3 | 150.8 |
| Diabetes Death Rate AA | 2006/4 | N/A | 28.2 | 24.4 | 27.3 | 23.2 | 29.7 | 24.7 |
| Infant Mortality /1000 | 2007/2 WA 2009/6 OR | 6.8 | 5.7 | 4.9 | 4.7 | 4.7 | 6.3 | 3.4 |
| Morbidity | | | | | | | | |
| Low Birth Weight | 2007/1 | 8.2% | 6.1% | 6.3% | 5.2% | 6.6% | 6.1% | 6.0% |
| Cancer Incidence /100,000 | 2007/7 | 464.5 | 465.6 | 479.1 | 467.0 | 460.9 | 466.0 | 428.2 |
| Heart Disease Ever Had | 2008/3 | 3.8% | 3.7% | 3.3% | N/A | N/A | N/A | N/A |
| Diabetes | 2008/1 | 8.0% | 6.9% | 7.0% | 7.7% | 8.4% | 7.3% | 6.4% |
| Asthma | 2008/1,3 | 13.3% | 14.9% | 14.9% | 14.9% | 16.9% | 14.3% | 13.7% |
| Health Status:good or excellent | 2008/5 | N/A | 85%% | 87% | 88% | 87% | 86% | 88% |
| Poor Mental Health Days (days per year) | 2008/5 | N/A | 3.3 | 3.3 | 2.8 | 3.2 | 3.7 | 2.9 |

Exhibit 4: Mortality and Morbidity Rates By Race and Ethnicity

| | Data Year/ Source | Total | Non-Hispanic White | Hispanic | Non- Hispanic Black | Native American | Asian/ Pacific Islander |
|----------------------------|-------------------------|-------|-----------------------|----------|---------------------------|--------------------|----------------------------|
| Mortality /100,000 | | | | | | | |
| Total Rate Age Adjusted AA | | | | | | | |
| Oregon | 2006/1 | 770.5 | 785.4 | 421.5 | 828.1 | 757.7 | 430.3 |
| Clackamas | 2006/1 | 766.5 | 783.2 | 426.6 | 683.3 | 824.7 | 376.5 |
| Multnomah | 2006/1 | 833.0 | 857.6 | 451.1 | 895.7 | 819.8 | 509.3 |
| Washington | 2006/1 | 684.7 | 711.2 | 312.7 | 1180.4 | 522.2 | 381.3 |
| Washington | 2006/1 | 722.5 | 735.4 | 467.2 | 903.6 | 904.6 | 462.7 |
| Clark | 2006/1 | 745.1 | 759.4 | 381.8 | 825.3 | 409.4 | 472.9 |
| Heart Death Rate AA | | | | | | | |
| Oregon | 2006/1 | 160.1 | 163.5 | 74.4 | 154.9 | 128.3 | 100.5 |
| Clackamas | 2006/1 | 161.4 | 166.8 | N/A | N/A | N/A | 64 |
| Multnomah | 2006/1 | 175.3 | 178.6 | 79.7 | 181.4 | 143.3 | 147.9 |
| Washington | 2006/1 | 146.2 | 152.1 | 24.8 | N/A | 343.4 | 78.3 |
| Washington | 2006/1 | 165.8 | 170.2 | 101.6 | 183.7 | 178.5 | 93.1 |
| Clark | 2006/1 | 176.7 | 179.2 | 91.1 | 179.7 | N/A | 114.7 |
| Cancer Death Rate AA | | | | | | | |
| Oregon | 2006/1 | 181.3 | 186.4 | 84.6 | 162.3 | 151.5 | 99.2 |
| Clackamas | 2006/1 | 187.8 | 192.1 | 68 | N/A | 266.7 | 107.2 |
| Multnomah | 2006/1 | 188.3 | 196.7 | 110.1 | 168.8 | 107.7 | 120.9 |
| Washington | 2006/1 | 150.8 | 158.5 | 59.1 | 269.8 | N/A | 72.8 |
| Washington | 2006/1 | 174.2 | 178.7 | 98.5 | 214.1 | 152.5 | 128.5 |
| Clark | 2006/1 | 176.0 | 178.9 | 61.5 | 86.9 | N/A | 159.7 |
| Diabetes Death Rate AA | | | | | | | |
| Oregon | 2006/1 | 28.2 | 27.2 | 36.5 | 62.4 | 80.3 | 29.5 |
| Clackamas | 2006/1 | 27.3 | 27.1 | N/A | N/A | N/A | N/A |
| Multnomah | 2006/1 | 29.7 | 27.8 | 24.5 | 62.6 | N/A | 26.8 |
| Washington | 2006/1 | 24.7 | 24.6 | N/A | N/A | N/A | 25.7 |
| Washington | 2006/1 | 24.4 | 23.7 | 26.2 | 57.6 | 40.2 | 21.5 |
| Clark | 2006/1 | 23.2 | 23.5 | N/A | N/A | N/A | N/A |
| | | | | | | | |
| | | | | | | | |

| | Data Year/ Source | Total | Non-Hispanic White | Hispanic | Non- Hispanic Black | Native American | Asian/ Pacific Islander |
|---|-------------------------|-------|-----------------------|----------|---------------------------|--------------------|----------------------------|
| Infant Mortality /1000 | | | | | | | |
| Oregon | 2006/2 | 5.6 | 5.5 | 5.4 | 9.4 | N/A | N/A |
| Washington | 2006/2 | 5.1 | 4.5 | 4.8 | 8.1 | N/A | N/A |
| Morbidity | | | | | | | |
| Low Birth Weight | | | | | | | |
| Oregon | 2007/2 | 6.1% | 5.9% | 5.9% | 9.8% | N/A | N/A |
| Washington | 2007/2 | 6.3% | 6.0% | 5.7% | 9.8% | N/A | N/A |
| Cancer Incidence AA /100,000 | | | | | | | |
| Oregon | 2006/2 | 456.5 | 450.2 | 340.8 | 356.5 | N/A | N/A |
| Washington | 2006/2 | 482.1 | 479.4 | 340.7 | 488.5 | N/A | N/A |
| Coronary Heart Disease Prevalence AA | | | | | | | |
| Oregon* | 2005/3 | 3.7% | 3.9-4.0% | 2.0-4.0% | 4.0-9.0% | 8.0-13.0% | 4.0-9.2% |
| Washington | 2005/3 | 3.3% | N/A | N/A | N/A | N/A | N/A |
| *Ranges based on 95% confidence | | | | | | | |
| Diabetes Prevalence AA | | | | | | | |
| Oregon | 2005/5 | 6.9% | 6% | 10% | 13% | 12% | 7% |
| Washington | 2005/6 | 7% | 6% | 9% | 14% | 12% | 9% |
| Asthma Ever Had | | | | | | | |
| Oregon | 2006/2 | 14.9% | 15.2% | 7.3% | 13.0% | N/A | N/A |
| Washington | 2006/2 | 14.9% | 14.5% | 10.0% | 14.7% | N/A | N/A |
| Adults Reporting Poor Mental Health | | | | | | | |
| Oregon | 2007/7 | 32.9% | 33.8% | N/A | N/A | N/A | N/A |
| Washington | 2007/7 | 35.0% | 35.3% | 26.8% | 30.5% | 48.4% | 30.8% |

Exhibit 5: Social Economic and Environment Determinant Factors

| | Data Year/ Source | Target 90 th percentile | OREGON | WASH. | Clackamas | Clark | Multnomah | Washington |
|---|-------------------------|--|----------|----------|-----------|----------|-----------|------------|
| Socio Economic | | | | | | | | |
| Education | | | | | | | | |
| High School Grad. 4 years | 2006/2 | 84% OR 89% WA | 73% | 73% | 75% | 77% | 73% | 78% |
| HS Grad. 25 yrs older | 2009/1 | N/A | 89.1% | 89.7% | 91.6% | 91.0% | 89.0% | 90.5% |
| College Degree 25 yrs older | 2009/1 | 31% | 29.2% | 31.0% | 32.7% | 24.2% | 39.1% | 38.3% |
| Employment | | | | | | | | |
| Unemployment | 2009/1 | | 11.8% | 9.5% | 11.1% | 12.5% | 11.5% | 10.6% |
| Income | | | | | | | | |
| Median Household Income | 2009/1 | N/A | \$48,475 | \$56,548 | \$59,876 | \$56,074 | \$50,773 | \$60,963 |
| All Poverty | 2009/1 | N/A | 14.3% | 12.3% | 9.2% | 11.8% | 15.1% | 10.2% |
| Children in Poverty (< 18) | 2009/1 | 13% | 19.2% | 16.2% | 13.5% | 16.9% | 19.6% | 12.7% |
| Home Ownership | 2009/1 | N/A | 63.1% | 64.3% | 70.4% | 64.3% | 54.9% | 62.2% |
| Rent 35% of HH Income | 2009/1 | N/A | 42.6% | 40.3% | 42.9% | 40.4% | 42.4% | 38.4% |
| Single Female Parent HH | 2008/1 | 7% | 10.1% | 10.1% | 9.1% | 10.8% | 10.7% | 9.8% |
| Crime | | | | | | | | |
| Violent Crime Rate /100,000 | 2007/2 | 117 | 285 | 342 | 126 | 237 | 638 | 157 |
| Physical Environment | | | | | | | | |
| Quality Environment | | | | | | | | |
| Air Pollution—Particulate Matter Days | 2005/2 | 0 | 4 | 2 | 4 | 3 | 4 | 25 |
| Built Environment | | | | | | | | |
| Access to Healthy Food: Census boundary .5 mile healthy food retailer | 2006/2 | 71% | 47% | 47% | 67% | 63% | 45% | 61% |
| Liquor Store Density | 2006/2 | N/A | .5 | .5 | .4 | .3 | .7 | .4 |

Exhibit 6: Social Economic Determinant Factors by Race and Ethnicity

| | | Data Year/ Source | Total | Non-Hispanic White | Hispanic | Black/African American | Native American | Asian/ Pacific Islander | 2 or more races |
|-----------------------------------|--------|-------------------------|----------|-----------------------|---------------|---------------------------|--------------------|-------------------------------|-----------------------|
| Education | | | | | | | | | |
| High School Grad 25 yrs older | OR | 2008/2,3 | 88.6% | 91.4% | 54.7% | 86.8% | 84.1% | 85.6% | 87.9% |
| College Degree 25 yrs older | WA | 2008,07/ 3,1 | 89.6% | 92.2% | 57.7% | 85.7% | 80.7% | 84.6% | 90.2% |
| College Degree 25 yrs older | OR | 2008/2 | 28.1% | 29.2% | 10.4% | 20.1% | 12.8% | 45.7% | 24.1% |
| | WA | 2008/3 2007/1 | 30.7% | 31.5% 2007 | 11.2% 2007 | 18.7% 2007 | 11.7% 2007 | 43.2% 2007 | 22.6% 2007 |
| Employment | | | | | | | | | |
| Unemploy. (16 older) | OR | 2009/3 | 11.8%* | 11.4% | 14.8% | 18.1% | 16.4% | 6.7% | N/a |
| * Nov 2010: 10.5% | Clack. | 2009/3 | 11.1% | 11.3% | 6.0% | - | - | - | N/a |
| | Mult. | 2009/3 | 11.5% | 10.2% | 18.6% | 17.7% | - | 8.2% | N/a |
| | Wash. | 2009/3 | 10.6% | 10.8% | 11.9% | - | - | 4.7% | N/a |
| | WA | 2009/3 | 9.5% | 9.1% | 10.8% | 15.3% | 17.1% | 6.8% | N/a |
| | Clark | 2009/3 | 12.5% | 12.0% | 16.3% | - | - | 6.1% | N/a |
| Income | | | | | | | | | |
| Median HH Income | OR | 2009/3 | \$48,457 | \$49,825 | \$35,861 | \$32,266 | \$34,072 | \$58,283 | |
| | Clack. | 2009/3 | \$59,876 | \$60,923 | \$43,136 | - | - | \$75,282 | |
| | Mult. | 2009/3 | \$50,733 | \$54,373 | \$36,356 | \$28,222 | \$23,173 | \$51,391 | |
| | Wash. | 2009/3 | \$60,963 | \$62,442 | \$40,386 | \$52,363 | \$49,133 | \$76,682 | |
| | WA | 2009/3 | \$56,548 | \$58,431 | \$42,532 | \$38,287 | \$42,393 | \$67,506 | |
| | Clark | 2009/3 | \$56,074 | \$56,763 | \$55,363 | \$30,985 | \$27,159 | \$70,805 | |
| Home Ownership | OR | 2009/4 | 65.9% | 70.9% | 48.0% | 44.5% | 54.6% | 59.0% | 51.9% |
| All Pov.<100% FPL | OR | 2008/2,3 | 13.6% | 11.2% | 25.8% | 29.4% | 26.5% | 12.8% | 17.4% |
| | WA | 2008/3 | 11.3% | 9.1% | 23.5% | 22.9% | 26.1% | 9.2% | 15.4% |
| Child Pov.<100% FPL | OR | 2008/2,3 | 18.1% | 12.9% | 33.2% | 37.7% | 32.9% | 11.9% | 16.5% |
| | WA | 2008/3 | 14.3% | | | | | | |
| Female Head HH w Children Poverty | OR | 2008/2 | | 34.2% | 54.3% | 55.8% | 44.2% | 37.6% | 47.0% |

Exhibit 7: Clinical Care and Behavior Health Factors

| | Data Year/ Source | Target 90 th percentile | ORE. | WASH. | Clackamas | Clark | Multnomah | Washington |
|--|------------------------|------------------------------------|--------|-------|-----------|-------|-----------|------------|
| Clinical Care | | - | | | | | | |
| Access | | | | | | | | |
| Uninsured 2010/2* | 2009/1 | N/A | 18.0%* | 12.5% | 13.2% | 12.8% | 16.8% | 14.8% |
| Uninsured Children 0-18 yrs | 2009/3 | 10% | 12% | 6% | N/A | N/A | N/A | N/A |
| Primary Care Provider /100,000 | 2007/5 | 175 | 133 | 136 | 107 | 102 | 211 | 123 |
| Prenatal Care First Trimester | 2006/4,5 | 83.2% | 79.2% | 70.3% | 82.8% | N/A | 78.4% | 85.6% |
| Diabetic Screening-65 yr | 2006/6 | 88% | 84% | 85% | 84% | 85% | 85% | 82% |
| Cholesterol Screening | 2009/6,7 | 77.0% | 73.9% | 72.9% | N/A | 75.0% | N/A | N/A |
| Sygmoidoscopy or | 2008/3 | 61.8% | 66.7% | 66.2% | N/A | N/A | N/A | N/A |
| Colonoscopy-50 yr plus | 2006/8 | | | | | | | |
| Pap Smears-18 yr plus | 2006/8 | N/A | 81.7% | 82.7% | 81.1% | 82.1% | 81.4% | 83.1% |
| Immunized: 19-35 months | 2009/3 | 72% | 67% | 75% | N/A | N/a | N/A | N/A |
| Quality | | | | | | | | |
| Preventable Hospital Stays | 2006/5 | 40,37 OR,WA | 49 | 50 | 42 | 61 | 46 | 45 |
| Behaviors | | | | | | | | |
| Tobacco Use Adult Smoking | 2009/5 OR 2010/7 WA | 14% | 19% | 14.8% | 17% | 14.4% | 20% | 14% |
| Teen Smoking | 2009/10 OR | N/A | 17% | 14% | 18% | 16% | 16% | 14% |
| WA: 10 th grade OR: 11 th grade | 2008/7 WA | | | | | | | |
| Diet Adult Obesity | 2009/9 | 26.9% | 23.6% | 26.9% | 24.2% | 32.1% | 20.5% | 18.6% |
| Adult Overweight | 2009/3 | 33.9% | 34.6% | 32.5% | N/A | N/A | N/A | N/A |
| Child 10-17 yrs | 2007/3 | 31.6% | 24.3% | 29.5% | N/A | N/A | N/A | N/A |
| Alcohol Use | | | | | | | | |
| Heavy Drinking (Women: 1 drink/day, Men: 2 drinks/day) | 2007/11 | N/A | 6.3% | N/A | 5.7% | N/A | 7.1% | 4.4% |
| Motor Vehicle Deaths /100,000 | 2006/5 | 8 | 14 | 12 | 11 | 10 | 9 | 8 |
| High Risk Sex | | | | | | | | |
| Chlamydia /100,000 | 2006/5 | 197 | 266 | 294 | 196 | 242 | 429 | 197 |
| Teen Births 15-19 yrs /1000 | 2006/5 | 24 | 37 | 34 | 24 | 35 | 39 | 33 |

Exhibit 8: Clinical Care and Behavior Health Factors by Race and Ethnicity

| | | Data Year/ Source | Total | Non-Hispanic White | Hispanic | Black/African American | Native American | Asian/ Pacific Islander |
|----------------------------------|----|-------------------------|-------------------|-----------------------|----------|---------------------------|--------------------|-------------------------------|
| Clinical Care | | | | | | | | |
| Access | | | | | | | | |
| Uninsured | OR | 2008/1 | 18.0% under 65 | 11.3% | 28.2% | 12.1% | 29.3% | 10.2% |
| | WA | 2007/2 | 12.5% | N/A | N/A | N/A | N/A | N/A |
| Prenatal Care First Trimester | OR | 2006/3 | 79.2% | 82.4% | 70.1% | 72.1% | N/A | N/A |
| | WA | 2006/3 | 70.3% | 74.0% | 60.5% | 63.7% | N/A | N/A |
| Behaviors | | | | | | | | |
| Tobacco Adults Smoking | OR | 2008/3 | 16.3% | 15.7% | N/A | N/A | N/A | N/A |
| | WA | 2008/3 | 15.7% | 15.6% | 12.2% | N/A | 37.5% | N/A |
| Diet | | | | | | | | |
| Adults Obese | WA | 2007/4 | 25% | 24% | 30% | 30% | 36% | 11% |
| Adults Overweight or Obese | OR | 2009/3 | 58.2% | 58.4% | N/A | N/A | N/A | N/A |
| <u> </u> | WA | 2009/3 | 59.4% | 60.0% | 57.5% | 74.3% | 70.8% | 37.4% |
| High Risk Sex | | | | | | | | |
| Teen Birth Rate /1000 | OR | 2007/5 | 35.9 | 27 | 93 | 44 | 54 | 15 |
| | WA | 2007/5 | 34.8 | 24 | 99 | 42 | 84 | 22 |

Exhibit 1: Demographics

- 1: US Census Bureau American Community Survey 2009 and 2006-2008. www.census.gov/acs
- 2: Portland State University Population Research Center. www.pdx.edu/prc
- 3: Oregon Department of Human Services Center for Health Statistics. http://www.dhs.state.or.us/dhs/ph/chs/data/birth/lb.shtml
- 4: Washington State Department of Health. Health Statistics. http://www.doh.wa.gov/ehsphl/chs/chs-data/birth/Bir Main.htm
- 5: Center for Disease Control User Guide to the 2007 Natality Public Use File. Cdc.gov/wonder/help/natality
- 6: Legacy Finance. PSU Population Research Center. www.pdx.edu.prc
- 7: Legacy Finance. Oregon Department of Administrative Services Office of Economic Analysis. Www.oregon.gov/DAS/OES/demographic

Exhibit 2: Demographics by Race and Ethnicity

- 1: Oregon Department of Human Services Office of Multicultural Health. www.oregon.gov/DHS/ph/omh
- 2: US Census Bureau American Community Survey 2008, 2009. cdc.gov/acs
- 3: Legacy Finance, Intelligmed Demographic Profile System.
- 4: Oregon Department of Human Services. Off0ice of Multicultural Health. www.oregon.gov/ph/mch Washington State OFM County Population Projections www.oregon.gov/ph/mch Washington State OFM County Population Projections www.ofm.wa.gov/pop/gma/projections , Clark County 2010-2014 Consolidated Housing and Community Development Plan www.co.clark.wa.us/cdbg/documents. US Census Bureau Quick Facts quickfacts.census.gov/qfd/states/41000.html
- 5: Kaiser Family Foundation State Health Facts. www.kff.org

Exhibit 3: Mortality and Morbidity Rates

- 1: Center for Disease Control. National Center for Health Statistics. www.cdc.gov/nchs
- 2: Oregon Department of Human Services Center for Health Statistics Vital Statistics. http://www.dhs.state.or.us/dhs/ph/chs/data
- 3: Center for Disease Control Community Health Status Report. Behavioral Risk Factor Surveillance System 2009. www.cdc.gov/brfss
- 4: US Department of Health and Human Services. Office of Women's Health. Health Data. www.healthstatus2010.c0m
- 5: County Health Rankings. www.countyhealthrankings.org
- 6: Washington State Department of Health Center for Health Statistics. http://www.doh.wa.gov/ehsphl
- 7: National Cancer Institute State Cancer Profiles 2003-2007. state cancer profiles.cancer.gov/incidencerates

Exhibit 4: Mortality and Morbidity Rates By Race and Ethnicity

- 1: US Department of Health and Human Services. Office of Women's Health. Health Data. www.healthstatus2010.c0m
- 2: Kaiser Family Foundation State Facts. www.kff.org
- 3: Oregon Department of Human Services. The Burden of Heart Disease and Stroke in Oregon. 2007. www.oregon.gov/DHS/ph/hdsp
- 4: US Department of Health and Human Services. Center for Disease Control National Center for Health Statistics. www.cdc.gov/nchs
- 5: Oregon Department of Human Services. The Burden of Diabetes in Oregon. http://www.oregon.gov/DHS/ph/diabetes/pubs.shtml
- 6: Washington State Department of Public Health 2007. Obesity and Diabetes Advisory Committee Policy Recommendations December 2009. healthequity.wa.gov/committees/diabetes/docs
- 7: US Census Bureau Current Population Survey Annual Social and Economic Supplement 2009. www.bls.census.gov/cps

Exhibit 5: Social Economic and Environment Determinant Factors

- 1: US Census Bureau American Community Survey 2009 and 2006-2008. www.census.gov/acs
- 2: County Health Rankings. www.countyhealthrankings.org

EXHIBIT 6: SOCIAL ECONOMIC DETERMINANT FACTORS BY RACE AND ETHNICITY

- 1: US Department of Education. National Center for Education Statistics. 2009. www.nces.ed.gov/programs/digest/d09/tables
- 2: Oregon Department of Human Services Office of Multicultural Health. www.oregon.gov/DHS/ph/omh
- 3: US Census Bureau American Community Survey 2008, 2009. www.census.gov/acs
- 4: 2010 Oregon Benchmark Race and Ethnicity Report: A Report on the Progress of Oregon's Racial and Ethnic Diverse Population. November 2010. www.oregon.gov/DAS/OPB/obm_pub

Exhibit 7: Clinical Care and Behavior Health Factors

- 1: US Census Bureau American Community Survey 2009 and 2006-2008. www.census.gov/acs
- 2: Oregon Office of Health Policy and Research. Email October 2010.
- 3: Kaiser Family Foundation State Health Facts. www.statehealthfacts.org/profile
- 4: Oregon Department of Human Services Center for Health Statistics Vital Statistics. http://www.dhs.state.or.us/dhs/ph/chs/data
- 5: County Health Rankings. www.countyhealthrankings.org
- 6: Center for Disease Control Chronic Disease Index 2009. www.cdc.gov/chronicdisease/index
- 7: Washington State Department of Health Chronic Disease Profile 2008 and 2010. www.doh.wa.gov/cfh/diabetes
- 8: US Department of Health and Human Services Community Health Status Indicators. www.communityhealth.hhs.gov/measures
- 9: Center for Disease Control Community Health Status Report. Behavioral Risk Factor Surveillance System 2009. www.cdc.gov/brfss
- 10: Oregon Tobacco Prevention and Education Program. http://oregon.gov/DHS/ph/tobacco/countyfacts
- 11: Oregon Health Policy Board and Oregon Health Authority. Oregon Health Improvement Plan Committee. Draft Oregon Health Improvement Plan: 2011-2020. October 2010. www/oregon.gov/DHS/[h/hpcdp/hip/index

Exhibit 8: Clinical Care and Behavior Health Factors by Race and Ethnicity

- 1: Oregon Department of Human Services Office of Multicultural Health. <u>www.oregon.gov/OHA/omhs</u>
- 2: Washington State Department of Human Services. www.insurance.wa.gov
- 3: Kaiser Family Foundation State Health Facts. www.kff.org
- 4: Washington State Department of Health Obesity and Diabetes Advisory Committee: Policy Recommendations December 10, 2009. healthequity.wa.gov/committees/diabetes
- 5: The National Campaign to Prevent Teen and Unplanned Pregnancy. State Profile. http://www.thenationalcampaign.org/state-data/state-profile.aspx?state=oregon, washington

Exhibit 9: Sources

Center for Disease Control Chronic Disease Index 2009. www.cdc.gov/chronicdisease/index

Center for Disease Control Community Health Status Report. Behavioral Risk Factor Surveillance System 2009. www.cdc.gov/brfss

Center for Disease Control. Defining Childhood Overweight and Obesity. www.cdc.gov/obesity/childhood/defining

Center for Disease Control. National Center for Health Statistics. www.cdc.gov/nchs

Center for Disease Control User Guide to the 2007 Natality Public Use File. Cdc.gov/wonder/help/natality

Clark County 2010-2014 Consolidated Housing and Community Development Plan. www.co.clark.wa.us/cdbg/documents

Coalition of Communities of Color and Portland State University. *Communities of Color in Multnomah County: An Unsettling Profile*. 2010. www.coalitioncommunitiescolor.com

County Health Rankings: Mobilizing Action Toward Community Health: 2010 Oregon and 2010 Washington. www.countyhealthrankings.org

Guttmacher Institute. US Trends Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity. www.guttmacher.org

Kaiser Family Foundation State Health Facts. www.kff.org, www.statehealthfacts.org/profile

Legacy Health Finance. Intelligmed Demographic Profile System.

Multnomah County Commission on Children and Families. *Improving Outcomes for Children and Families of Multnomah County Six* – Year Plan. 2008.

The National Campaign to Prevent Teen and Unplanned Pregnancy. State Profile. www.thenationalcampaign.org/state-data/state-profile.aspx?state=oregon,washington

National Cancer Institute State Cancer Profiles 2003-2007. www.statecancerprofiles.cancer.gov/incidencerates

North Carolina Department of Health and Human Services. Office of Healthy Carolinians/Health Education and the State Center for Health Statistics. *Community Assessment Guidebook*. 2002. www.schs.state.nc.us.

Oregon Department of Human Services. *The Burden of Diabetes in Oregon.* www.oregon.gov/DHS/ph/diabetes/pubs

Oregon Department of Human Services. *The Burden of Heart Disease and Stroke in Oregon*. 2007. www.oregon.gov/DHS/ph/hdsp

Oregon Department of Human Services Center for Health Statistics Vital Statistics. http://www.dhs.state.or.us/dhs/ph/chs/data

Oregon Department of Human Services Office of Multicultural Health. www.oregon.gov/DHS/ph/omh

Oregon Health Policy Board and Oregon Health Authority. Oregon Health Improvement Plan Committee. *Draft Oregon Health Improvement Plan: 2011-2020.* October 2010. www.oregon.gov.DHS/ph/hpcdp/hip/index

Oregon Perinatal Data Book 2007. www.oregon.gov/dhs/ph/pnh/docs/databook 2007

Oregon Progress Board. 2009 Benchmarks. www.benchmarks.oregon.gov

Oregon Progress Board. *Oregon Benchmark Race and Ethnicity Report: A Report on the Progress of Oregon's Racial and Ethnic Diverse Population*. November 2010. www.oregon.gov/DAS/OPB/obm_pubs

Oregon Department of Human Services. Oregon Tobacco Prevention and Education Program. http://oregon.gov/DHS/ph/tobacco/countyfacts

Portland Plan. http://www.portlandonline.com/portlandplan

Portland State University Institute of Metropolitan Studies. *Population Dynamics of the Portland-Vancouver MSA*. May 2010. http://mkn.research.pdx.edu/2010/05/population-dynamics

Portland State University Population Research Center November 2010. www.pdx.edu/prc

Robert Wood Johnson Foundation. Commission to Build a Healthier America. www.commissiononhealth.org

Roth, Richard and Eileen Barsi. The Community Need Index. Health Progress. July-August 2005.

The National Campaign to Prevent Teen and Unplanned Pregnancy. State Profile. http://www.thenationalcampaign.org/state-data/state-profile.aspx?state=oregon

The Oregonian. Oregon's Income Gap Widens. December 1, 2010.

Trust for America's Health. *F for Fat Report*. http://healthyamericans.org/reports/obesity2009/release.php?stateid=OR

US Census Bureau American Community Survey 2009 and 2006-2008. cdc.gov/acs

US Census Bureau Current Population Survey Annual Social and Economic Supplement 2009. www.bls.census.gov/cps

US Census Bureau. quickfacts.census.gov/qfd/states/41000.html

US Department of Education. National Center for Education Statistics. 2009. www.nces.ed.gov/programs/digest/d09/tables

US Department of Health and Human Services. Community Health Status Indicators. communityhealth.hhs.gov/measures

US Department of Health and Human Services. Office of Women's Health. Health Data. www.healthstatus2010.c0m

Waidman, Timothy. Estimating the Cost of Racial and Ethnic Health Disparities. The Urban Institute. September 2009

Washington Health Foundation. 2010 Healthiest State Report Card. www.whf.org/policy-priorities/2010

Washington State Behavioral Risk Factor Surveillance System 2008. www.doh.wa.gov/ehsphl/chs/chs-data/brfss/brfss

Washington State Department of Health. Chronic Disease Profile 2008. www.doh.wa.gov/data/chronic

Washington State Department of Health. *Communicable Disease Report 2009*. www.doh.wa.gov/notify/annlrpt/cdr2009

Washington State Department of Health. Health Statistics. http://www.doh.wa.gov/ehsphl

Washington State Department of Health News Release Sept. 4, 2008. *Immunization rates in Washington decrease slightly*. http://www.doh.wa.gov/Publicat/2008 news/08-147.htm

Washington State Department of Health Obesity and Diabetes Advisory Committee: *Policy Recommendations*. December 10, 2009. www.healthequity.wa.gov/committees/diabetes/docs

Washington State Department of Human Services. Uninsured, www.insurance.wa.gov

Washington State OFM County Population Projections. www. Ofm.wa.gov/pop/gma/projections.

World Health Organization Social Determinants of Health. http://www.who.int/social_determinants/en/

Appendix A
Community Health Characteristics: Most Important

| Issue | Number | Percent |
|--------------------------|--------|---------|
| Education | 33 | 25.6% |
| Income/Jobs | 31 | 24.0% |
| Health Care and Access | 29 | 22.5% |
| Housing | 14 | 10.9% |
| Social/Human Services | 10 | 7.8% |
| Community Involvement | 10 | 7.8% |
| Public Health | 10 | 7.8% |
| Environment | 6 | 4.7% |
| Public Safety | 5 | 3.9% |
| Economic Development | 5 | 3.9% |
| Mental Health | 2 | 1.6% |
| Equity | 2 | 1.6% |
| Nutrition/Hunger | 1 | 0.8% |
| Dental | 1 | 0.8% |
| Early Childhood | 1 | 0.8% |
| Libraries, Museums, Arts | 1 | 0.8% |
| Revenue/Public Services | 1 | 0.8% |
| Total | 129 | 100.0% |

Appendix B
Community Health: Greatest Needs/Issues

| Issue | Number | Percent |
|--|--------|---------|
| Income/Jobs | 30 | 19.5% |
| Education | 23 | 14.9% |
| Health Care and Access | 21 | 13.6% |
| Diversity//Disparities/Equity/Culturally | | |
| Appropriate Services | 19 | 12.3% |
| Affordable Housing | 9 | 5.8% |
| Mental Health | 7 | 4.5% |
| Health | 6 | 3.9% |
| Dental | 5 | 3.2% |
| Addiction/ Substance Abuse | 5 | 3.2% |
| Economy Funding | 4 | 2.6% |
| Poverty | 3 | 1.9% |
| Public Health | 3 | 1.9% |
| Environment | 3 | 1.9% |
| Obesity | 3 | 1.9% |
| Early Childhood | 2 | 1.3% |
| Nutrition/Hunger | 2 | 1.3% |
| Public Safety | 2 | 1.3% |
| Chronic Disease | 1 | 0.6% |
| Transportation | 1 | 0.6% |
| Civic Involvement | 1 | 0.6% |
| Childhood Obesity | 1 | 0.6% |
| Adult Literacy | 1 | 0.6% |
| Domestic Violence | 1 | 0.6% |
| HIV/AIDS | 1 | 0.6% |
| Total | 154 | 100.0% |

Appendix C
Health Care and Public Health: Greatest Issues

| Issue | Number | Percent |
|---|--------|---------|
| Healthcare or Access Specified | 21 | 10.8% |
| Cost | 15 | 7.7% |
| Coverage | 12 | 6.2% |
| Primary Care Shortage/Access | 8 | 4.1% |
| Cultural Competency | 7 | 3.6% |
| Care Coordination | 3 | 1.5% |
| Medical Homes | 1 | 0.5% |
| Disparities, Equity, Racism | 10 | 5.2% |
| Workforce Diversity | 6 | 3.1% |
| Mental Health | 20 | 10.3% |
| Addiction/ Substance Abuse | 15 | 7.7% |
| Chronic Diseases | 11 | 5.7% |
| Obesity | 11 | 5.7% |
| Dental | 10 | 5.2% |
| Nutrition/Hunger | 8 | 4.1% |
| Prevention and Education | 7 | 3.6% |
| Built Environment | 6 | 3.1% |
| Violence: Domestic and Child | 5 | 2.6% |
| Public Health | 3 | 1.5% |
| Seniors | 3 | 1.5% |
| Prenatal Care | 3 | 1.5% |
| Early Childhood | 2 | 1.0% |
| Tobacco | 1 | 0.5% |
| Childhood Obesity and Physical Activity | 1 | 0.5% |
| Natural Environment | 1 | 0.5% |
| Autism | 1 | 0.5% |
| Disasters-Medical and Natural | 1 | 0.5% |
| Transgender Care | 1 | 0.5% |
| HIV/AIDS | 1 | 0.5% |
| Total | 194 | 100.0% |

Appendix D Hospitals' Roles

| Issue | Number | Percent |
|---|--------|---------|
| Partner with Community Organizations: \$, Services, Labor | 22 | 25.6% |
| Prevention Education | 8 | 9.3% |
| Collaboration with other Health Systems | 7 | 8.1% |
| Health Access: Uncompensated Care | 7 | 8.1% |
| Advocate with Legislature, Elected Officials | 6 | 7.0% |
| Health Access: Affordability, Reduce Costs | 6 | 7.0% |
| Public/Private Sector Partnerships | 5 | 5.8% |
| Mental Health | 4 | 4.7% |
| Culturally Appropriate/Competent Care | 4 | 4.7% |
| Education: Health Workforce | 4 | 4.7% |
| Employment Diversity | 4 | 4.7% |
| Be Accessible | 3 | 3.5% |
| Conveners regarding Issues | 3 | 3.5% |
| Social Determinants | 2 | 2.3% |
| Dental | 1 | 1.2% |
| Total | 86 | 100.0% |

Appendix E Needs/Issues Ranked by Priority Ranking Based on Criteria: Size, Seriousness, Change Potential, Capacity, Strategic Focus

| Need/Issue | Criteria | Rating 1 (low) 5 (high) | Total Score |
|---|------------------|-------------------------------|----------------|
| Access Covered Cost Cultural | Size | 5 | |
| Access: Coverage, Cost, Cultural | Seriousness | 5 | |
| Competency, Health Literacy, Location, Availability, Primary Care Shortage, | Change Potential | 4 | |
| Medical Homes, Care Management | Capacity | 4 | |
| Medical Florites, Care Management | Strategic Focus | 5 | 23 |
| | | | |
| | Size | 4 | |
| | Seriousness | 5 | |
| Health Literacy | Change Potential | 5 | |
| | Capacity | 4 | |
| | Strategic Focus | 4 | 22 |
| | | | |
| | Size | 4 | |
| Disparities/Equity/Racism: Disease | Seriousness | 5 | |
| Rates, Services, Workforce Diversity | Change Potential | 4 | |
| rates, Services, Workforce Diversity | Capacity | 4 | |
| | Strategic Focus | 4 | 21 |
| | | | |
| | Size | 4 | |
| | Seriousness | 5 | |
| Youth and Education | Change Potential | 4 | |
| | Capacity | 4 | |
| | Strategic Focus | 4 | 21 |
| | 0. | | |
| | Size | 5 | |
| 01 . 5: | Seriousness | 5 | |
| Chronic Disease and Obesity | Change Potential | 3 | |
| | Capacity | 3 | |
| | Strategic Focus | 4 | 20 |
| | Size | 4 | |
| | Seriousness | 4 | |
| Prevention and Education | Change Potential | 3 | |
| 1 levelition and Education | Change Fotential | 3 | |
| | Strategic Focus | 4 | 18 |
| | Strategic i Ocus | 4 | 10 |
| | Size | 3 | |
| | Seriousness | 5 | |
| Mental Health | Change Potential | 3 | |
| iviciitai i leattii | Change Potential | 3 | |
| | Strategic Focus | 3 | 17 |
| | otrategic i ocus | 3 | 17 |
| | Size | 2 | |
| | Seriousness | 5 | |
| Prenatal Care | Change Potential | 3 | |
| | | 3 | |
| | Capacity | ્ ા | |

| | | 1 | |
|---|------------------|--|------|
| | Size | 4 | |
| Addiction/Substance Abuse | Seriousness | 5 | |
| | Change Potential | 3 | |
| Addiction/Odbstance/Abase | Capacity | 3 | |
| | Strategic Focus | 2 | 17 |
| | Chategie i coas | | - 17 |
| | Size | 3 | |
| | Seriousness | 4 | |
| Seniors | Change Potential | 3 | |
| Comoro | Capacity | 3 | |
| | Strategic Focus | 3 | 16 |
| | Strategie i code | | 10 |
| | Size | 3 | |
| | Seriousness | 4 | |
| Violence: Domestic and Child | Change Potential | 3 | |
| 1.0.000. 20000 00 | Capacity | 2 | |
| | Strategic Focus | 2 | 14 |
| | | | |
| | Size | 4 | |
| | Seriousness | 4 | |
| Public Health | Change Potential | 2 | |
| | Capacity | 2 | |
| | Strategic Focus | 2 | 14 |
| | Change For | _ | |
| | Size | 4 | |
| | Seriousness | 4 | |
| Dental | Change Potential | 2 | |
| | Capacity | 1 | |
| | Strategic Focus | 2 | 13 |
| | | | |
| | Size | 3 | |
| | Seriousness | 4 | |
| Childhood Obesity and Physical Activity | Change Potential | 3 | |
| | Capacity | 1 | |
| | Strategic Focus | 2 | 13 |
| | | | |
| | Size | 4 | |
| | Seriousness | 4 | |
| Nutrition/Hunger | Change Potential | 2 | |
| ŭ | Capacity | 2 | |
| | Strategic Focus | 1 | 13 |
| | | | |
| | Size | 2 | |
| | Seriousness | 4 | |
| Tobacco | Change Potential | 3 | |
| | Capacity | 2 | |
| | Strategic Focus | 2 | 13 |
| | | | |
| | Size | 4 | |
| | Seriousness | 4 | |
| Built Environment | Change Potential | 2 | |
| | Capacity | 2 | |
| | Strategic Focus | 1 | 13 |

| | Size | 3 | |
|--------------------------------|------------------|---|----|
| | Seriousness | 3 | |
| Natural Environment | Change Potential | 2 | |
| | Capacity | 2 | |
| | Strategic Focus | 1 | 11 |
| | | | |
| | Size | 2 | |
| | Seriousness | 3 | |
| Early Childhood | Change Potential | 3 | |
| | Capacity | 2 | |
| | Strategic Focus | 1 | 11 |
| | | | |
| | Size | 2 | |
| | Seriousness | 3 | |
| HIV/AIDs | Change Potential | 2 | |
| | Capacity | 2 | |
| | Strategic Focus | 1 | 10 |
| | | | |
| | Size | 2 | |
| | Seriousness | 3 | |
| Disasters: Medical and Natural | Change Potential | 2 | |
| | Capacity | 1 | |
| | Strategic Focus | 1 | 9 |
| | | | |
| | Size | 1 | |
| | Seriousness | 3 | |
| Transgender Care | Change Potential | 2 | |
| | Capacity | 1 | |
| | Strategic Focus | 1 | 8 |
| | | | |
| | Size | 1 | |
| | Seriousness | 2 | |
| Autism | Change Potential | 1 | |
| | Capacity | 1 | |
| | Strategic Focus | 1 | 6 |

Appendix F Community Needs Assessment 56 Interviewees

| Name | Organization | Expertise |
|--|--|---|
| Venetta Abdellatif, Director, | Multnomah County Health | Expertise in public health, |
| Integrated Services | Department | disparities and FQHCs |
| Judy Alley, | Snow Cap | Expertise in serving low income |
| Executive Director | Show Cap | families |
| Thomas D. Aschenbrener, | Northwest Health | |
| President/CEO | Foundation | |
| Michael Balter, | Boys and Girls Aid Society | Expertise in serving low income |
| Executive Director | Boys and Gins Ald Society | Expertise in serving low income |
| Carolyn Becic, | Oregon Mentors | |
| Executive Director | Oregon Mentors | |
| Cindy Becker, Administrator | Clackamas County Health and Human Services | Expertise in public health and serving low income |
| The Right Rev. David | Oregon Lutheran Synod | Serving lew interne |
| Brauer-Rieke, Bishop | ELCA | |
| Rachel Bristol, | | Expertise in serving low income |
| Executive Director | Oregon Food Bank | families |
| Sam Brooks, | Oregon Association of | Expertise in dedicated to |
| Former President | Minority Entrepreneurs | communities of color equity |
| Lorena Campbell, | East Multnomah County | Expertise in education |
| Liaison | Schools Liaison | achievement for all youth |
| Margaret Carter, | | - |
| Deputy Director of Human | Oregon Department of | Expertise in serving low income |
| Services | Human Services | and communities of color |
| Gale Castillo, | Hispanic Metropolitan | Organization dedicated to |
| Executive Director | Chamber | Hispanic community equity |
| Robin Christian, Executive Director | Children First for Oregon | |
| Lisa Cline, | The Wallace Medical | Safety net clinic for low income, |
| Executive Director | Concern | medically underserved |
| Jeff Cogen, Chair | Multnomah County | modically directives |
| Rodney Cook, | Clackamas Office of | Expertise in serving low income |
| Director | Children and Families | families |
| | Portland State University | Academic researcher in social |
| Carlos Crespo, DrPh, | School of Community | determinants and communities of |
| Director | Health | color disparities |
| Marie Dahlstrom, Executive Director | Familias en Accion | Expertise in serving Hispanic and medically underserved |
| | Oregon Association of | medically underserved |
| Andy Davidson, | Hospitals and Healthcare | |
| President/CEO | Systems | |
| Marty Davis, Publisher | Just Out | Expertise in LGBT population |
| Chris DeMars, | | Expertise in EGD1 population |
| Program Officer | NW Health Foundation | |
| Jean DeMaster, | | _ , , |
| Executive Director | Human Solutions | Expertise in serving low income |
| Kevin Dowling, | 04550454 | |
| Program Manager | CARES NW | Expertise in child abuse |
| Erin Fair, Policy Director | Care Oregon | Expertise in serving low income |
| Pietro Ferrari, | Hacienda | Expertise in serving Hispanic |
| Executive Director | | community |
| Jeana Frazzini, | Basic Rights Oregon | Expertise in LGBTQ needs |

| Executive Director | | |
|--|---------------------------|---|
| Joanne Fuller, Director, | Multipage als Carrets | Expertise in urban county human |
| Human Services | Multnomah County | services |
| Bruce Goldberg, MD, | Oregon Department of | Expertise in public health and |
| Director | Human Services | medically underserved |
| | Mt. Hood Community | incursumy arraeres rea |
| Janie Griffin, Dean | College | |
| Guadalupe Guajardo, | Nonprofit Association of | Expertise in culturally competent |
| Senior Consultant | Oregon | training and consultation |
| Mary Lou Hennrich, | Oregon Public Health | _ |
| Executive Director | Institute | Expertise in public health |
| Donna Larson, | Mt. Hood Community | |
| Dean of Allied Health | College | |
| David Leslie, | Ecumenical Ministries of | Expertise in social justice for the |
| Executive Director | Oregon | disenfranchised |
| Marc Levy, | United Way of the | Expertise in services for low |
| Executive Director | Columbia Willamette | income |
| Adrienne Livingston, | Colditible Willattictic | Expertise in disparities for |
| Executive Director | Black United Fund | communities of color |
| | Native American Youth | |
| Nichole Maher, | | Expertise in disparities for Native |
| Executive Director | and Family Center | American community |
| Diane McKeel, | Multnomah County | |
| Commissioner | | |
| Corliss McKeever, | African American Health | Expertise in health disparities for |
| President/CEO | Coalition | African Americans |
| Laurie Monnes-Anderson, State Senator | Oregon State Senate | RN and expertise in public health |
| Vicki Nakashima | Partners in Diversity | Expertise in increasing equity for communities of color |
| Carol Neilson-Hood, | Gresham Area Chamber | |
| Executive Director | of Commerce | |
| Linda Nilsen-Solares, | Decised Assess NOW | Expertise in health care low |
| Executive Director | Project Access NOW | income medically underserved |
| Carman Rubio, | | Expertise in reducing disparities |
| Executive Director | Latino Network | for Hispanics |
| Jim Schlachter, | Gresham Barlow School | |
| Superintendent | District | |
| Lillian Shirley, | Multnomah County Health | Expertise in public health and |
| Director | Department | health disparities |
| John Sygielski, EdD,, | Mt. Hood Community | noann diopannoc |
| President | College | |
| Lynn Thompson, | Big Brothers Big Sisters | Expertise in serving low income |
| CEO | Columbia Northwest | families |
| | Oregon Multicultural | Expertise in health disparities for |
| Tricia Tillman, Administrator | | |
| | Health and Services | communities of color |
| Joshua Todd, | Multnomah County | Expertise in serving low income |
| Director | Commission on Children, | communities |
| | Families and Community | |
| Greg Van Pelt, Chief | Providence Health and | |
| Executive Oregon | Services Oregon Region | |
| Maree Wacker, | American Red Cross | |
| CEO | Oregon Trail Chapter | |
| Larry Wallack, DrPH, | Portland State University | Expertise as academic researcher |
| Dean | College of Urban and | in social determinants and |
| | Public Affairs | disparities |

| Joyce White, | Grantmakers of OR and | Expertise funding disparities for |
|-------------------------------------|---------------------------|---|
| Executive Director | SW WA | communities of color |
| Wim Wievel, PhD, President | Portland State University | |
| Gloria Wiggins, Division Manager | El Programa Hispano | Expertise in serving the Hispanic community |

Legacy Mount Hood Medical Center Implementation Strategies Plan

Needs/Issues listed in order of ranking from Community Needs Assessment Secondary Data and Interviews Appendix E. *Italics designate racial and ethnic community focus*.

| Action | Impact | | |
|---|---|--|--|
| NEED: Access to care: Charity Care, Coverage, Cost, Location, A | | | |
| and Access, Medical Homes, Care Coordination and Cultural Com | | | |
| Health services for low income uninsured based on charity care | Access to care for those in need. | | |
| financial policies, i.e., up to 400% of FPL. | | | |
| Financial, service and labor support to Project Access NOW which | Increases quality and reduced | | |
| links low income uninsured to health services provided at no charge. | morbidity and mortality for low- | | |
| | income uninsured through access to | | |
| | services at earlier stages. | | |
| Partnership with Familias en Accion: social and navigational support | Reduces mortality and morbidity | | |
| for diabetes and cancer and breast health and prostate screenings | disparities in Hispanic community. | | |
| for Hispanic patients. | | | |
| Financial support and participation in Oregon Public Health ALERT | Increases immunization rates | | |
| Immunization Registry. | through tracking. | | |
| Financial and inkind lab services and board representation to | Increases access for low income | | |
| Wallace Medical Concern safety net clinic. | uninsured. | | |
| Financial support to Ride Connection for transportation services | Enables low income and seniors to | | |
| provided at no cost for seniors and people with disabilities to medical | obtain medical care. | | |
| appointments. | Improved the health and suchtage | | |
| Exercise and support groups open to all people with cancer. | Improves the health and quality of | | |
| Largery Devery Fire Institute was iidea from any disease agreenings at | life for cancer patients. | | |
| Legacy Devers Eye Institute provides free eye disease screenings at | Increases detection and care of | | |
| public events and follow-up care for low income for patients requiring | glaucoma and eye diseases at early stages, particularly for high risk | | |
| care. | populations. | | |
| Explore financial and inkind support to Sandy School Based Health | Improve health access for teens. | | |
| Center. | Improve nealth access for teens. | | |
| Explore support for community health workers serving communities | Improves quality of care and | | |
| with high mortality and morbidity rates. | outcomes for communities of color. | | |
| NEED: Health Literacy | | | |
| Financial grant to increase health literacy in high need high poverty | Improves quality of care and | | |
| high Hispanic zip code, Rockwood; grantee project organizations | outcomes in at-risk populations, i.e., | | |
| include Wallace Medical Concern, Human Solutions, Metropolitan | communities of color and seniors. | | |
| Family Service, Mt. Hood Headstart, Loaves and Fishes. | | | |
| Wallace Medical Concern Mobile Van Medical Director serves as | Increases understanding and impact | | |
| member of Legacy Health Literacy/CLEAR Council. | in the community, particularly | | |
| , | communities of color. | | |
| Host, with Legacy HealthOregon and SW Washington Health | Improves health outcomes and | | |
| Literacy Conference. | quality. Reduces racial and ethnic | | |
| | disparities. | | |
| NEED: Disparities, Equity, Workforce Diversity, Disease Rates, Services, Institutional Racism | | | |
| Employment requires management positions and above to include | Increases workforce diversity. | | |
| interviewees of color; waiver required for positions not fulfilling this | | | |
| requirement. | | | |
| Offer Youth Employment in Summers (paid summer employment | Increases the diversity of the health | | |
| (\$4800) and college scholarships (\$2500-\$5000) for Hispanic | care workforce—2-3 students | | |
| students entering health care careers). | annually over 10 years. | | |
| NEED: Youth and Education | | | |
| Provide high school health care job shadows and internships: Center | Increases health care workforce. | | |
| for Advanced Learning and David Douglas High School | | | |

| Provide clinical rotation sites for Mt. Hood Community College health care programs. | Increases health care workforce. |
|--|---|
| Provide In-kind and financial contributions and/or board | Increases education opportunities |
| representation to education efforts e.g., partner schools, Gresham | for students. |
| Barlow Schools Foundation, Mt. Hood Community College | |
| Foundation. | |
| Hospital Teen Volunteer Program enables students to gain familiarity | Increases familiarity with health care |
| to health care professions. | professions and required education |
| | levels. |
| Offer Youth Employment in Summers (paid summer employment | Increases the diversity of the health |
| (\$4800) and college scholarships (\$2500-\$5000) for Hispanic | care workforce—2-3 students |
| students entering health care careers). | annually over 10 years. |
| NEED: Chronic Disease and Obesity | , |
| Weight loss program and incentive challenges offered to employees. | Reduces obesity and chronic |
| | diseases among employees—and |
| | their families. |
| Participate in City of Gresham HEAL (Healthy Eating Active Living) | Reduces obesity and increases |
| community Program. | public health. |
| NEED: Prevention and Education | |
| Hold Legacy Mount Hood Health and Safety Kids Fair for the | Increases health and safety |
| community at no charge. | education and awareness among |
| , , | families |
| Bike, skateboard, ski and snowboard helmets sold for \$5 at | Reduces traumatic injuries. 5000 |
| community events in Gresham. | sold annually across the metro |
| , | Portland area. |
| Free mammograms to low income and women of color. | Reduces cancer mortality and |
| , and the second | morbidity. |
| Provide car seats at no charge for low income families leaving birth | Increases safety for newly born |
| center. | babies. |
| Legacy Devers Eye Institute provides free eye disease screenings at | Increases detection of glaucoma and |
| public events. | eye diseases at early stages, |
| | particularly for high risk populations. |
| NEED: Mental Health | |
| Limited resources prevent addressing as a priority need. | |
| NEED: Prenatal Care | |
| Scholarships for low income women to attend childbirth classes. | Decreases low birth weight rates. |
| NEED: Addiction/Substance Abuse | |
| Limited resources prevent addressing as priority need. | |
| NEED: Seniors | |
| Provide financial donation to Ride Connection transporting seniors to | Increases access to medical care. |
| medical appointments at no charge. | |
| Hospital volunteer services offers adults, primarily seniors, | Increases mental and physical |
| opportunity to provide service to patients and families. | health and reduces probability of |
| , | illness among seniors. |
| NEED: Violence: Domestic and Child | , |
| Sister hospital—Legacy Emanuel—is site of CARES NW which | Reduces the trauma associated with |
| evaluates and cares for children suspected of child abuse. | child abuse. |
| Collaborators: Providence Health and Services, Kaiser Permanente | |
| and Courts. | |
| NEED: Public Health | |
| Limited resources prevent addressing as priority need. | |
| NEED: Dental | |
| Limited resources prevent addressing as a priority need. | |
| NEED: Nutrition/Hunger | |
| Host summer weekly Farmers Markets at the hospital. (See Built | Increases access to healthy food for |
| | |

| Environment) | employees, patients and public. |
|--|---|
| Participate in Gresham Farmers Market. (See Built Environment) | Improves access to healthy food for the public. |
| Offer annual employee food drive for local SnowCap food pantry. | Reduces hunger for families. |
| NEED: Childhood Obesity and Physical Activity | |
| Limited resources prevent addressing as priority need. | |
| NEED: Tobacco | |
| Hospital campus is tobacco-free. | Increased public awareness and |
| | reduction in tobacco-related |
| | diseases from limited access. |
| NEED: Built Environment | |
| Offer weekly summer Farmers Market on-site. | Increases access to healthy food for |
| | employees, patients and public. |
| Offer Hospital Healing Garden open to the public. | Natural quiet environment available |
| | to patients, employees and public. |
| Food, equipment and supplies recycled and sustainability practices implemented. | Reduces green-house emissions. |
| Offer conference rooms available to public sector and nonprofit | Reduces need for additional event |
| organizations at no charge. | space in city and enables nonprofits |
| | to focus on missions. |
| Participate in Gresham Farmers Market. | Improves access to healthy food |
| Decree define a la collection for a la collect | choices for the public. |
| Representation on boards and donations to economic and workforce | Increases employment and job |
| development (East Metro Economic Alliance, Gresham Chamber, | creation. |
| West Columbia Gorge Chamber, Mt. Hood Community College). NEED: Natural Environment | |
| | |
| Limited resources prevent addressing as priority need. NEED: Early Childhood | |
| Limited resources prevent addressing as priority need. | |
| NEED: HIV/AIDS | |
| Limited resources prevent addressing as priority need. | |
| NEED: Disasters: Medical and Natural | |
| Participate in regional disaster preparedness. | Improves community's ability to |
| Tartiolpate in regional disaster preparedness. | contend with natural disasters. |
| NEED: Transgender Care | |
| Limited resources prevent addressing as priority need. | |
| | |
| NEED: Autism | |